Amendment No. 1 to SB1345

Bailey
Signature of Sponsor

AMEND Senate Bill No. 1345 House Bill No. 1503*

by deleting all language after the enacting clause and substituting:

SECTION 1. The commissioner of commerce and insurance shall conduct a study on the implementation of the federal No Surprises Act (Pub. L. No. 116-260) and its implications for physicians and healthcare facilities in this state. The report must include any recommendations the commissioner deems appropriate for state-level solutions to issues or challenges that may exist under or persist despite implementation of the No Surprises Act; recommendations for legislative changes by the general assembly; and recommendations for administrative rule changes in this state. When conducting the study, the commissioner shall solicit input from healthcare providers, healthcare facilities, and insurance companies. The commissioner shall deliver a copy of the report to the chair of the commerce and labor committee of the senate, the chair of the insurance committee of the house of representatives, and the legislative librarian no later than November 1, 2023.

SECTION 2. Tennessee Code Annotated, Section 56-7-2356(a)(2), is amended by deleting the subdivision and substituting:

(2)

(A) Each managed health insurance issuer shall:

(i) File a network adequacy standards description with the commissioner, review the description for adequacy and compliance with this section, and update the description annually; and

(ii) Report to the commissioner each material change to an approved network plan at least fifteen (15) days before such change,

including each change that would result in a failure to satisfy the requirements of this section. Upon receiving the report, the commissioner shall reevaluate the issuer's network plan for compliance with the network adequacy standards of this section.

(B) As used in this subdivision (a)(2), "material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of ten percent (10%) or more of a specific type of provider in a geographic market, the removal of a major health system that causes a network to be significantly different from the network when the beneficiary enrolled in the network plan, or a change that would cause the network to no longer satisfy the requirements of this section or the commissioner's rules for network adequacy.

(3) In an effort to ensure that consumers within a geographic region have an adequate opportunity to select an in-network provider, including specialty providers and facilities, and to avoid unanticipated out-of-network costs, the network adequacy standards description must include a report for each network hospital that provides the percentage of providers in each of the specialties of emergency medicine, anesthesiology, radiology, radiation oncology, pathology, and hospitalists practicing in the hospital who are in the health benefit plan's network.

SECTION 3. Tennessee Code Annotated, Section 56-7-2356(b)(4), is amended by deleting "annually" and substituting "quarterly".

SECTION 4. Tennessee Code Annotated, Section 56-7-2356(b)(9), is amended by deleting the subdivision and substituting:

(9) A sufficient number of contracted providers practicing at the same in-network facilities with which the managed health insurance issuer has contracted to reasonably ensure enrollees have complete and comprehensive in-network access for covered services delivered at those in-network facilities; and

(10) Other information required by the commissioner to determine compliance with this part.

SECTION 5. Tennessee Code Annotated, Section 56-7-2356, is amended by adding the following as new subsections:

(g) If the commissioner determines that a managed health insurance issuer has not met the sufficiency standards established by this section, then the commissioner shall require a modification to the network or may institute a corrective action plan to ensure access for enrollees. The commissioner may take other disciplinary action for violations of this section as permitted pursuant to § 56-2-305, and in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(h) The commissioner shall develop an appeals procedure and forms where an enrollee of the managed health insurance issuer, contractor of a managed health insurance issuer, or a healthcare provider or facility may file a request for review of network adequacy and sufficiency of the managed health insurance issuer network. The department shall complete such review within ninety (90) days of submission to the department.

SECTION 6. The commissioner of commerce and insurance is authorized to promulgate rules to effectuate this act. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 7. The headings in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 8.

(a) For the purpose of promulgating rules and carrying out administrative duties necessary to effectuate this act, this act takes effect July 1, 2023, the public welfare requiring it.

(b) SECTION 1 of this act takes effect upon becoming a law, the public welfare requiring it.

(c) For all other purposes, the remainder of this act takes effect January 1, 2024, the public welfare requiring it.